

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

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07216

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07194

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY St. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY St. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL COMPTON		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES DAWKINS ABELL		First JAMES	Middle DAWKINS
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRIC LINE TRIMMER		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country) MARYLAND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-48-8726	17. INFORMANT J. DAWKINS ABELL
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9115 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH discovered	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) His body grounded a truck which touches? Not wire	
20c. TIME OF INJURY Month, Day, Year Hour 105 p.m. 5-31 1967		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street
20f. (City or town) St. Clements Shore St. Mary Md		(County) St. Mary	(State) MD
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>William D. Boyd</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) WILLIAM D. BOYD M. D.		22. DATE SIGNED 6/1/67
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 6 - 3 - 1967	23c. NAME OF CEMETERY OR CREMATORIUM ST. JOHNS CEMETERY	23d. LOCATION (City or Town) (County) (State) HOLLYWOOD, MARYLAND
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND	ADDRESS	25a. RECD BY REGISTRAR JUN 5 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07195

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M		07217				07195					
1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREAT MILLS, Drayden 181		d. STREET ADDRESS					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) HELEN		First MAE		Middle ADAMS		4. DATE OF DEATH MAY 19, 1967					
S. SEX FEMALE	6. COLOR DR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH AUG. 28, 1883		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME HENRY W. ADAMS				14. MOTHER'S MAIDEN NAME ELIZABETH ANN REDMAN							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
				MARGARET A. BISCOE DRAYDEN, MARYLAND							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO last. (c)				<i>Cerebral hemorrhage</i> <i>Generalized osteoporosis</i>							
				INTERVAL BETWEEN ONSET AND DEATH <i>days</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized osteoporosis -											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5/19		20f. (City or town) (County) (State) 5/19	
21. I certify that (I) (this hospital) attended the deceased from 5/19/67 to 5/19/67 , that (I) (we) last saw the deceased alive on 5/19/67 , and that death occurred on 5/19/67 , from causes and on the date stated above.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22a. SIGNATURE <i>JAMES P. JARBOE</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/22/67							
22c. PHYSICIAN'S NAME (Type) JAMES P. JARBOE M.D.		22d. ADDRESS GREAT MILLS, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 21, 1967		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ST. GEORGE EPISCOPAL		23d. LOCATION (City or Town) (County) (State) VALLEY LEE					
24. FUNERAL DIRECTOR W. CLARKE MATTINGEY LEONARDTOWN, MARYLAND				25a. REC'D BY REGISTRAR MAY 23 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07196

07218

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to a burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN lb 1/2 HOUR	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY LUCILLE BANAGAN		First MARY	Middle LUCILLE
4. DATE OF DEATH MAY 7 1967	Month MAY	Day 7	Year 1967
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/> X NEVER MARRIED	8. DATE OF BIRTH FEB. 17, 1915
9. AGE (In years last birthday) 52 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME CHARLES DOWNS		
14. MOTHER'S MAIDEN NAME MARY WILKINSON	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		
16. SOCIAL SECURITY NO. 217-30-1010	17. INFORMANT JOSEPH S. BANAGAN	Address AVENUE, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 724 X DUE TO Massive Bilateral Thromboembolic Embolus INTERVAL BETWEEN ONSET AND DEATH 30 min			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO Surgery of knee (post op Comp) last. (c) DUE TO Traumatic arthro & bursitis 3 wk			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell over cinder block at work -	
20c. TIME OF INJURY Month, Day, Year Hour pm 5 35 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Capt Sam Seeger
20f. (City or town) Bushwood		(County) St. Mary's	
(State) MD			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE WILLIAM D BOYD MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WILLIAM D BOYD MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) BUSHWOOD ST. MARY'S MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 10, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS SACRED HEART CEMETERY LEONARDTOWN, MD.		23d. LOCATION (City or Town) (County) (State) BUSHWOOD ST. MARY'S MD.	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS LEONARDTOWN, MD.		25b. REGISTRAR'S SIGNATURE MAY 17 1967	

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FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07197

0721S

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland Ohio	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River		c. LENGTH OF STAY IN Tb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River // Dayton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL AIR STATION HOSPITAL		d. STREET ADDRESS 1801 West Riverview NAVAL/AIR/STATION Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES H. BLAKLEY, Jr.		First CHARLES	Middle H.
4. DATE OF DEATH May 31, 1967	Last BLAKLEY, Jr.	Month May	Day 31
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED	8. DATE OF BIRTH JAN. 21, 1945
9. AGE (In years last birthday) 22 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. NAVY	10b. KIND OF BUSINESS OR INDUSTRY	9. IF UNDER 1 YEAR Months 22
11. BIRTHPLACE (State or foreign country) ALABAMA	12. CITIZEN OF WHAT COUNTRY? U.S.A.	10. IF UNDER 24 HRS Days 0	Hours 0
13. FATHER'S NAME CHARLES H. BLAKLEY	14. MOTHER'S MAIDEN NAME	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES	
16. SOCIAL SECURITY NO.	17. INFORMANT U.S. NAVY RECORDS	Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Gunshot wound of chest			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by unknown assailant	
20c. TIME OF INJURY Month, Day, Year Hour XXX 8:00 p.m. 5-31 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway
20f. (City or town) (County) (State) Dameron St. Mary's Md.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles S. Springate</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		22. DATE SIGNED June 1, 1967
EXAMINER'S NAME (Type) Charles S. Springate, M.D.	ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF JUNE 5, 1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ANTIOCH CEMETERY EUFAULA, ALABAMA	23d. LOCATION (City or Town) (County) (State) EUFALA, ALABAMA
24. FUNERAL DIRECTOR FRED SMITH	25a. RECD BY REGISTRAR DATE JUN 6 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

YOUNG & SPURGEON

BOBBINS

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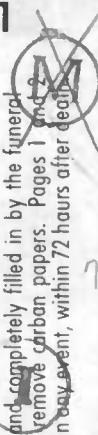
YOUNG & SPURGEON 25 JUNE 1940

HTMB 3387

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #7 Film #G388 5/15/67 pc

07220

07198

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN,	c. LENGTH OF STAY IN lb 7 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL LOVEVILLE,	d. STREET ADDRESS 181
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First HAMMETT	Middle CHING	Last MAY 3, 1967
4. DATE OF DEATH MAY 3, 1967	Month MAY	Day 3	Year 1967
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 19	B. DATE OF BIRTH MARCH 2, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 75
13. FATHER'S NAME VOLLEY CHING		14. MOTHER'S MAIDEN NAME EMILY ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) WW 1		16. SOCIAL SECURITY NO. 213-22-0207	17. INFORMANT Address BEATRICE FULLER LOVEVILLE, MARYLAND
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 197X DUE TO Bimarial Pneumonia — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Carcinoma of Prostate - Metastasis (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 15, 1967 , to 5/3, 1967 , that (I) (we) last saw the deceased alive on 5/3, 1967 , and that death occurred at 5/3, 1967 M, from causes and on the date stated above.			
22a. SIGNATURE Charles Greenwell		22b. DATE SIGNED 5/4/67	
22c. PHYSICIAN'S NAME (Type) CHARLES GREENWELL M. D.		22d. ADDRESS LEONARDTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/6/67	23c. NAME OF CEMETERY OR CREMATORIUM CHRIST CHURCH	23d. LOCATION (City or Town) (County) (State) CHAPTICO ST. MARY'S MD.
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25a. REC'D BY REGISTRAR MAY 9 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and an event, within 72 hours after death.

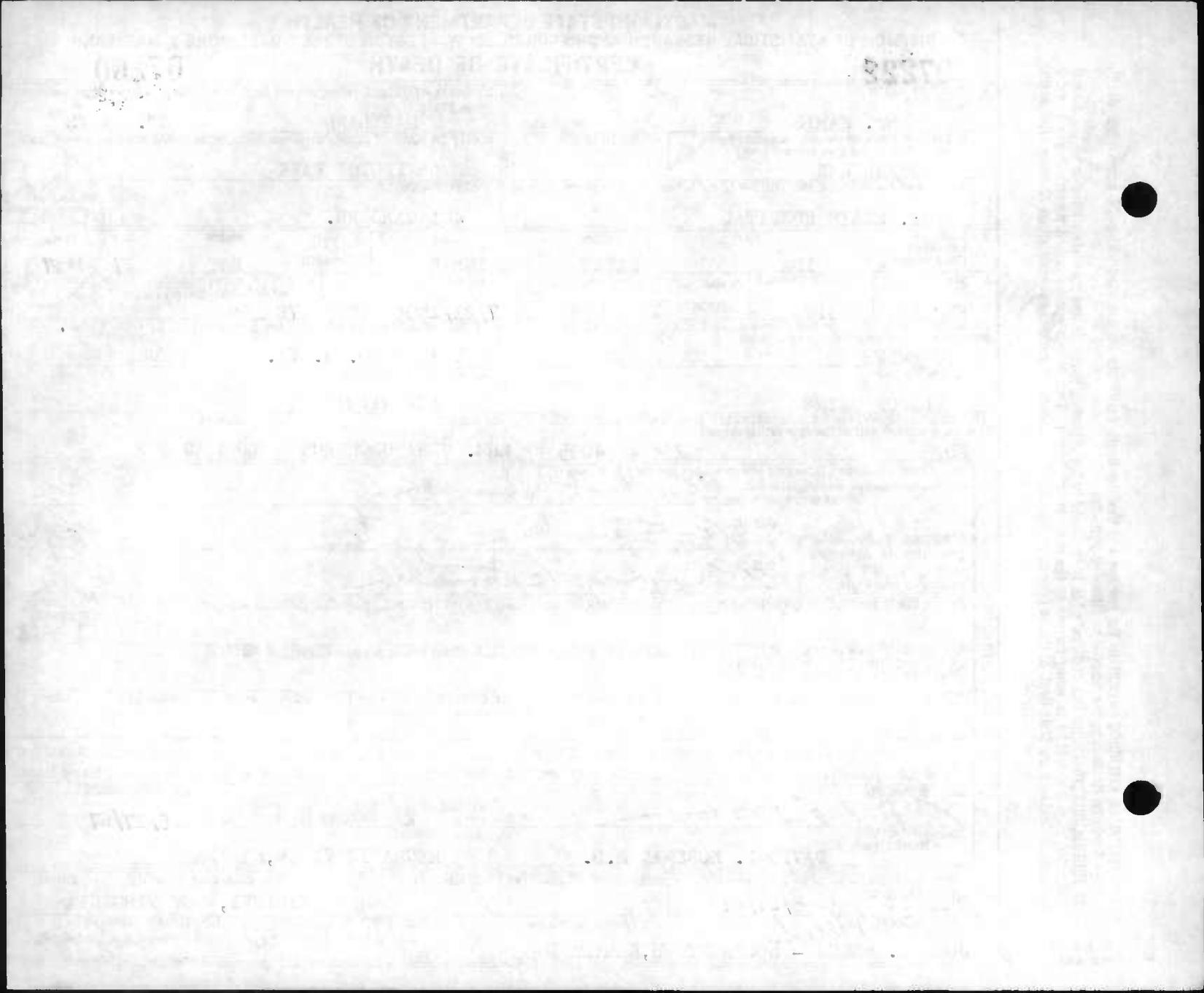
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07222

CERTIFICATE OF DEATH

07200

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEXINGTON PARK 18:1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARYS HOSPITAL			d. STREET ADDRESS 401 CARD RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First IDA	Middle SAYRE	Last DADISMAN	4. DATE OF DEATH MAY 27 1967
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/21/1894	9. AGE (in years last birthday) 72 yrs.	10. UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (County & State, or foreign country) TAYLOR CO. W. VA. 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LABON SAYRE			14. MOTHER'S MAIDEN NAME IZA RILEY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 234 46 4095		17. INFORMANT Address MRS. VERA UPCHURCH SAME AS # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>External Hemorrhage</i> <i>4201</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Extremity System</i> (c) <i>De Compressive Extremity</i> INTERVAL-BETWEEN ONSET AND DEATH <i>2 days</i> <i>10 days</i> <i>10 days</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED while at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____, M, from the causes and on the date stated above.					
22a. SIGNATURE <i>J. L. Mossman</i> 22b. DATE SIGNED <i>5/27/67</i>					
22c. PHYSICIAN'S NAME (Type) DAVID L. MOSSMAN M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS MECHANICSVILLE, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANSIT		23b. DATE THEREOF 5/27/67		23c. NAME OF CEMETERY OR CREMATORIAL PHILIPPI, WEST VIRGINIA	
24. FUNERAL DIRECTOR JOHN M. WELCH		ADDRESS JOHN M. WELCH - LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR JUN 1 1967 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07223		CERTIFICATE OF DEATH		07201			
1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b RURAL AVENUE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 181			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES HENRY DYSON		First CHARLES	Middle HENRY	Last DYSON	4. DATE OF DEATH MAY 21, 1967		
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 4, 1882		9. AGE (In years last birthday) yrs. 85	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RICHARD DYSON		14. MOTHER'S MAIDEN NAME ANNIE ? ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT JAMES EDWARD DYSON AVENUE, MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493X DUE TO Cardiac failure Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO Pneumonia lost. (c)						INTERVAL BETWEEN ONSET AND DEATH	
19. MEDICAL CERTIFICATION						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 21. I certify that (I) (this hospital) attended the deceased from 2/10/65, to 5/27/65, that (I) (we) last saw the deceased alive on 2/14/65, and that death occurred at 22A M, from causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE Charles Greenwell		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 1967	
22c. PHYSICIAN'S NAME (Type) CHARLES GREENWELL M. D.				22d. ADDRESS LEONARDTOWN, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 1967		23c. NAME OF CEMETERY OR CREMATORIAL SACRED HEART CEMETERY		23d. LOCATION (City or Town) (County) (State) BUSHWOOD, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR MAY 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #8 Film #G389 6/2/67 pc

CERTIFICATE OF DEATH

07202

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 20 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL LEONARDTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) PHILIP XOXOHN L. EVANS		First	Middle	Last	4. DATE OF DEATH MAY 26, 1967
S. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1896	9. AGE (In years last birthday) 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) CALIFORNIA, MARYLAND	
13. FATHER'S NAME FRANK EVANS			14. MOTHER'S MAIDEN NAME HENERITTA SHORT		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MAMIE EVANS Address LEONARDTOWN, MARYLAND	
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thromboses INTERVAL BETWEEN ONSET AND DEATH 5 hr. 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-arteric heart disease 10+ yr. (c) Hypertension 10+ yr.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from causes and on the date stated above.					
22a. SIGNATURE <i>John F. Fenwick</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5-27-67
22c. PHYSICIAN'S NAME (Type) John F. Fenwick M.D.		22d. ADDRESS Leonardtown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 29, 1967	23c. NAME OF CEMETERY OR CREMATORIAL ST. JOHNS CEMETERY	23d. LOCATION (City or Town) (County) (State) HOLLYWOOD, ST. MARY'S, MD.	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND			ADDRESS	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE MAY 31 1967

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

07225

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07203

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River		c. LENGTH OF STAY IN lb 10 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Station Hospital NAS PAX RIV MD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Roy Richard Grey Jr.		First	Middle
S. SEX Male	6. COLOR OR RACE Cau	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. NAVY		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roy Richard Grey		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1966-1967		16. SOCIAL SECURITY NO. 301 34 6780	17. INFORMANT Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Multiple Internal Injuries DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Auto Accident DUE TO (c)		2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in POV which overturned	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1:02 p.m. 22 May 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway - Hollywood, St. Mary's, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 22 May 1967	
ACTUAL SIGNATURE H.C. ROBISON, LT MC USN		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W.D. BOYD, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF May 27, 1967	23c. NAME OF CEMETERY OR CREMATORIAL OAK HILL
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		ADDRESS	25a. REC'D BY REGISTRAR MAY 25 1967
			25b. REGISTRAR'S SIGNATURE J. Charles J. Geiger

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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07226

CERTIFICATE OF DEATH

07204

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 1 HOUR	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NELLIE ELLEN HERBERT		First	Middle
4. DATE OF DEATH MAY 18, 1967		Last	Month
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> NEVER MARRIED	8. DATE OF BIRTH JUNE 11, 1907
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (County & State, or foreign country) MARYLAND
13. FATHER'S NAME GEORGE ARMSTRONG		14. MOTHER'S MAIDEN NAME MARY DELLA THOMAS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT JOSEPH EDWARD HERBERT BUSHWOOD, MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Oedema INTERVAL BETWEEN ONSET AND DEATH 10 min 443x DUE TO Arteriosclerotic Cardiovascular Disease Hypertension 10 sec Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus 4 hr (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 6 Blu. ph. dehydrogenase P.A.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1957 , 19, to 1967 , 19, that (I) (we) last saw the deceased alive on May 18, 1967 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE J. Morris		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/20/67
22c. PHYSICIAN'S NAME (Type) D L MOSSMAN M.D.		22d. ADDRESS MECHANICSVILLE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 22, 1967	23c. NAME OF CEMETERY OR CREMATORIUM SACRED HEART CEMETERY
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		ADDRESS	25a. REC'D BY REGISTRAR MAY 23 1967
			25b. REGISTRAR'S SIGNATURE James Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07227

CERTIFICATE OF DEATH

07205

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
2
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN lb 22 HOURS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM ARTHUR HUNTINGTON		First WILLIAM	Middle ARTHUR
4. DATE OF DEATH MAY 13, 1967	Month MAY	Day 13,	Year 1967
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> B. DATE OF BIRTH AUG. 25, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LOUIS B. HUNTINGTON		14. MOTHER'S MAIDEN NAME Sarah HILL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 216-40-7697 A	
17. INFORMANT DELLA M. HUNTINGTON HUGHESVILLE, MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201		INTERVAL BETWEEN ONSET AND DEATH immediate	
IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Coronary Occlusion			
DUE TO (b) DUE TO (c) Chestnutown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. May 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Dray
20f. (City or town) Dray		(County) (State) Dray	
21. I certify that (I) (this hospital) attended the deceased from May 1967 to May 1967 that (I) (we) last saw the deceased alive on May 1967 , and that death occurred at Dray M, from causes and on the date stated above.			
22. SIGNATURE J. D. Morris		22b. DATE SIGNED 5/15/67	
22c. PHYSICIAN'S NAME (Type) 		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS MECHANICSVILLE, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 16, 1967	23c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL CEMETERY
23d. LOCATION (City or Town) SUITLAND		(County) (State) MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		25a. ADDRESS 	25b. REC'D BY REGISTRAR
		25c. REGISTRAR'S SIGNATURE W. Clarke Mattingley	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

07229

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07207

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL RIDGE		c. LENGTH OF STAY IN lb			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MARYLAND STATE ROUTE # 5		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) RALPH STERLING KELLY (KELLEY)		First RALPH	Middle STERLING		
4. DATE OF DEATH MAY 20, 1967	Month MAY	Day 20	Year 1967		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIVIL SERVICE		9. AGE (In years last birthday) 49 yrs.			
10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) AKRON, OHIO			
13. FATHER'S NAME STERLING KELLY		14. MOTHER'S MAIDEN NAME ISABELLE FLINN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 269-12-4299			
17. INFORMANT ELEANOR ANN KELLEY		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fraction of skull DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour 10:30 p.m. Month May Day 20 Year 1967		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Auto out of control struck utility pole and overturned.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 5		20f. (City or town) (County) (State) 15 miles S of Rudy Rd St Marys, Md			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE P.J. BEAN M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED May 24 1967	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 25, 1967		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ST. PAUL'S CEMETERY LEONARDTOWN, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25. RECEIVED BY REGISTRAR DATE MAY 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH								07208	
1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY St. Mary's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARK HALL RURAL		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN, 18-1		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) STATE ROUTE #5									
3. NAME OF DECEASED (Type or print)		First JOHN	Middle MICHAEL	Lost	4. DATE OF DEATH	Month MAY	Doy 7,	Year 1967	
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 4, 1944	9. AGE (In years lost birthday) 22 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Dofs <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Months <input type="checkbox"/> Dofs <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LEONARDTOWN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Leo P. Klear				14. MOTHER'S MAIDEN NAME ALICE				Address Mrs Marjorie B. Klear LEONARDTOWN, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple severe injuries including</i> <i>825X</i> DUE TO <i>extensive fracture of skull</i> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO <i>immediate</i> stating the underlying cause (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident</i>							
20c. TIME OF INJURY Month, Doy, Year Hour o.m. <i>2:30</i> p.m. <i>May 7 1967</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> Date <i>Route 5</i>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>2 miles south of Great Mills, St. Mary's, Md.</i>		20f. (City or town) <i>Great Mills</i> (County) <i>St. Mary's</i> (State) <i>Md.</i>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									22. DATE SIGNED <i>5/7/67</i>
ACTUAL SIGNATURE <i>P. J. Bean M.D.</i>		EXAMINER'S NAME (Type) P. J. BEAN M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Leonardtown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 9, 1967		23c. NAME OF CEMETERY OR CREMATORIUM St. Aloysius CEMETERY		23d. LOCATION (City or Town) LEONARDTOWN, MARYLAND		(County) <i>St. Mary's</i> (State) <i>Md.</i>	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY				ADDRESS Leonardtown, Maryland		25a. REC'D BY REGISTRAR DATE MAY 9 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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Journal of Aging Studies

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CHALMERS UNIVERSITY OF TECHNOLOGY MAINTAINING INNOVATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ST. MARY'S		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN,		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HOLLYWOOD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		d. STREET ADDRESS ROUTE 1		d. DATE OF DEATH MAY 15, 1967		Month Day Year	
3. NAME OF DECEASED (Type or print) CHARLES LEO KRUG		First	Middle	Lost	Month	Day	Year
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 30, 1892	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME CHARLOTTE M. HARVEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
				MARY A. KRUG HOLLYWOOD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse INTERVAL BETWEEN ONSET AND DEATH miss 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction min DUE TO (c) Coronary Artery Disease yes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1967 to 1967, that (I) (we) last saw the deceased alive on 5/15/67 and that death occurred at 9 AM, from causes and on the date stated above.							
22a. SIGNATURE <i>James P. Jarboe</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/18/67			
22c. PHYSICIAN'S NAME (Type) JAMES P. JARBOE M. D.		22d. ADDRESS GREAT MILLS, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 17, 1967		23c. NAME OF CEMETERY OR CREMATORIAL ST. JOHNS CEMETERY		23d. LOCATION (City or Town) (County) (State) HOLLYWOOD, ST. MARY'S, MD.	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR MAY 19 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

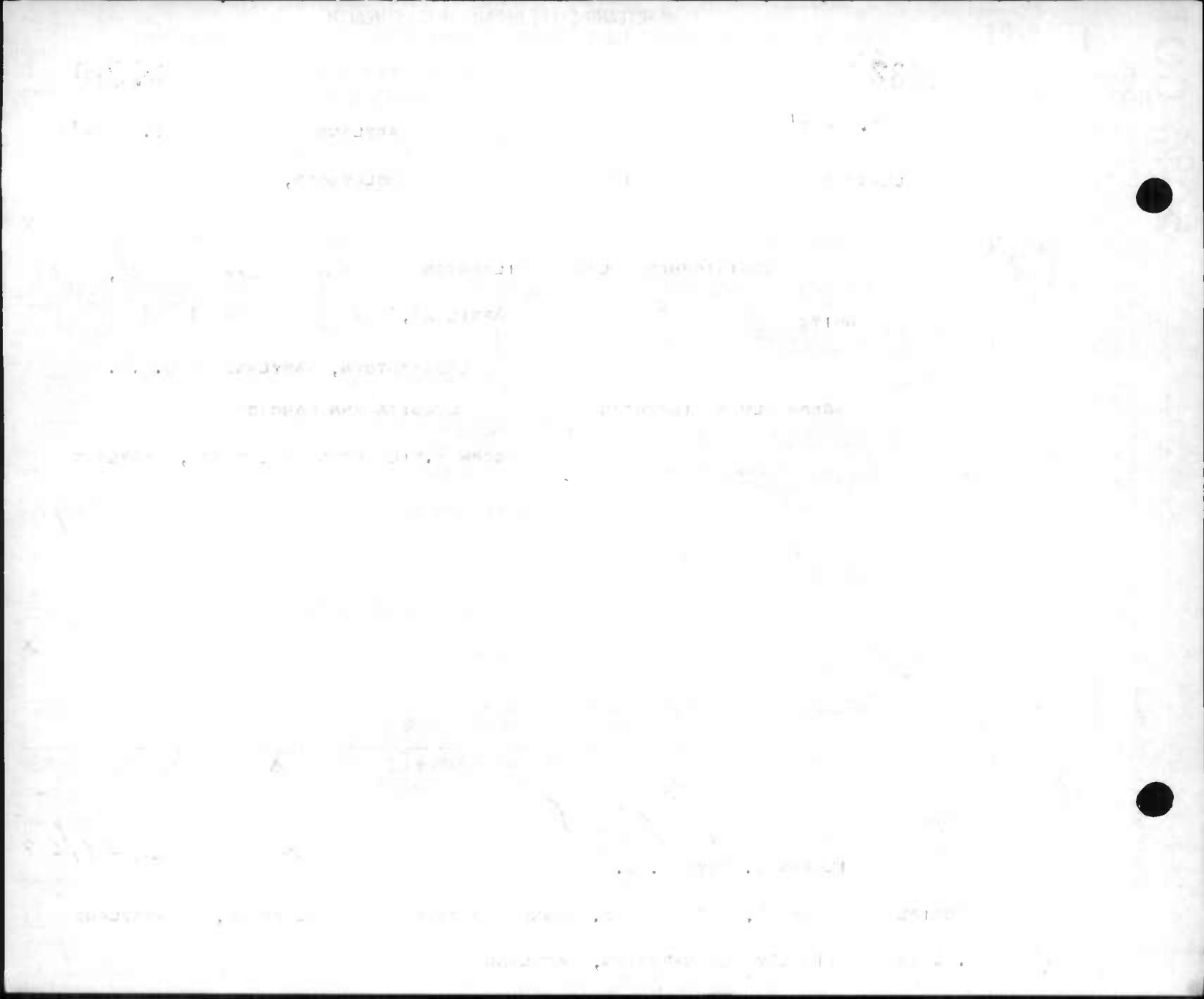
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

37232

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07210

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HOLLYWOOD		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First CHRISTOPHER	Middle ALAN
		Last PILKERTON	4. DATE OF DEATH MAY 29, 1967
S. SEX Male	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input type="checkbox"/> 8. DATE OF BIRTH APRIL 23, 1967
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME JOSEPH ELMER PILKERTON		11. BIRTHPLACE (State or foreign country) LEONARDTOWN, MARYLAND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ((If yes give war or dates of service))		16. SOCIAL SECURITY NO.	
17. INFORMANT JOSEPH E. PILKERTON		Address HOLLYWOOD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493X DUE TO Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) HOLLYWOOD		(County) (State) MARYLAND	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>William D. Boyd</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) WILLIAM D. BOYD M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 30, 1967	23c. NAME OF CEMETERY OR CREMATORIUM ST. JOHNS CEMETERY
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND	25a. REG'D BY REGISTRAR JUN 1 1967
			b. REGISTRAR'S SIGNATURE <i>James J. Judge</i>



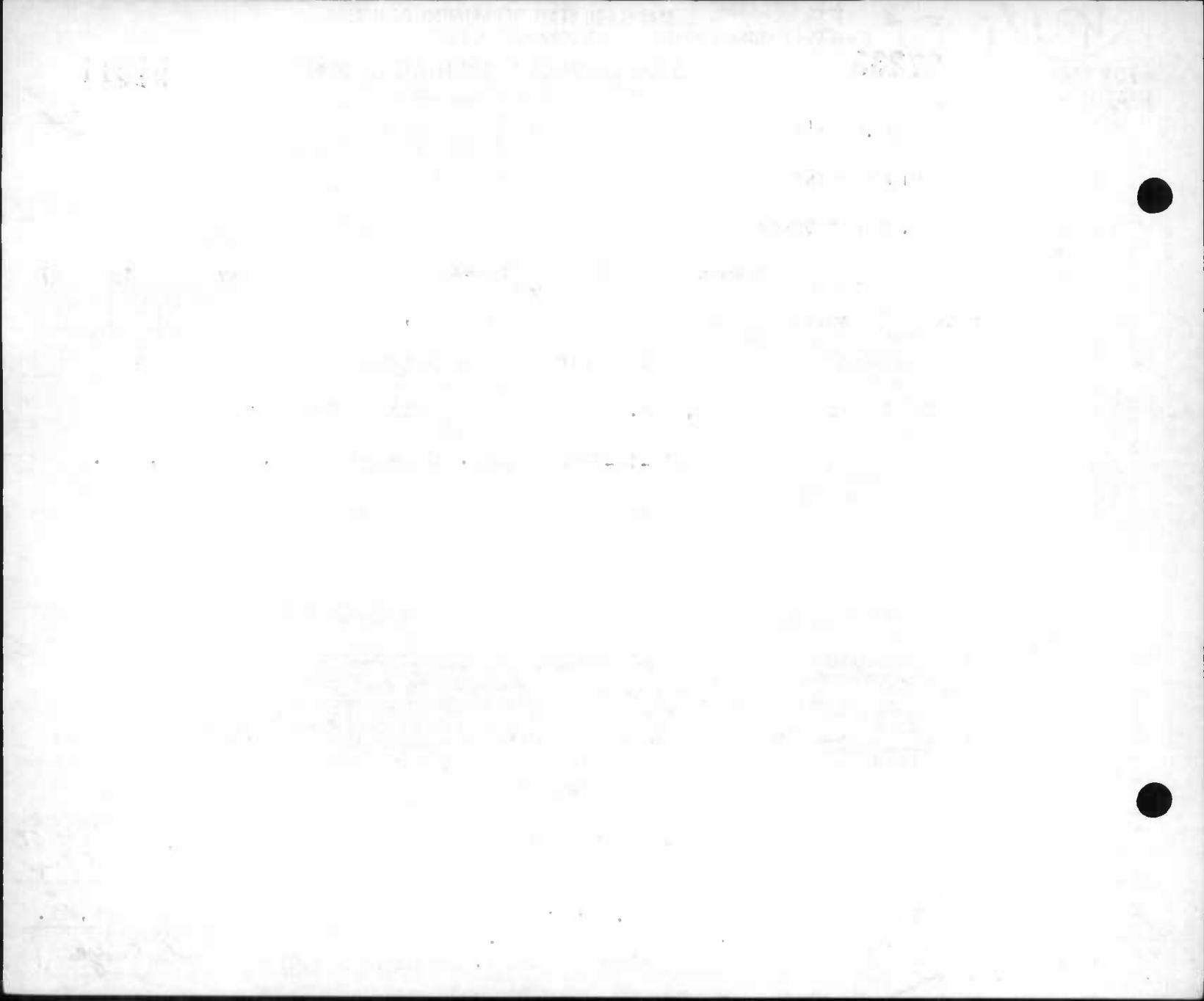
FOR STATE
HEALTH DEPT.

1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PN3. Page 5 may be retained for your files.

2
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

3
18

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
07233						07211					
1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PINEY POINT			c. LENGTH OF STAY IN lb 2 weeks			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wenona					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. GEORGE CREEK						d. STREET ADDRESS Main Road					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First NORMAN	Middle R	Last THOMAS	4. DATE OF DEATH MAY 15 1967		Month MAY	Day 15	Year 1967		
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1917		9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterman			10b. KIND OF BUSINESS OR INDUSTRY tugboat			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Ira Thomas, Sr.						14. MOTHER'S MAIDEN NAME Hilda Webster					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO. 216-16-7682			17. INFORMANT Mrs. Ella Webster, Wenona, Md.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 9348 DUE TO Conditions, if any, which gave rise to immediate cause (a), (b) _____ stating the underlying cause _____ DUE TO last. (c) _____											
INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Tornado force wind cause tug boat to sink								
20c. TIME OF INJURY Month, Day, Year Hour a.m. 5 p.m. May 15 1967			20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) North of St. George Creek			20f. (City or town) St. George Creek (County) St. Mary's (State) Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Leroy G. Webster			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county) Great Mills, St. Mary's					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 5/22/67		23c. NAME OF CEMETERY OR CREMATORIUM St. Paul's Cemetery			23d. LOCATION (City or Town) (County) (State) Wenona Somerset, Md.				
24. FUNERAL DIRECTOR Leroy G. Webster		ADDRESS Princess Anne, Md.		25a. REC'D BY REGISTRAR MAY 24 1967			25b. REGISTRAR'S SIGNATURE Charles Judge				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07234

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07212

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PINEY POINT c. LENGTH OF STAY IN lb 2 weeks				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WENONA d. STREET ADDRESS Main Road				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. GEORGE CREEK				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First WILLIAM	Middle IRA	Lost	4. DATE OF DEATH MAY 15 1967	Month	Doy Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 4, 1924	9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterman				10b. KIND OF BUSINESS OR INDUSTRY tugboat	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Ira Thomas, Sr.				14. MOTHER'S MAIDEN NAME Hilda Webster				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 218-16-5553	17. INFORMANT Mrs. Eva Thomas	Address Wenona, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Boatwreck DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Tornado force wind caused tug boat to sink						
20c. TIME OF INJURY Month, Day, Year Hour o.m. 5 p.m. May 15 1967		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) boat of St George Creek		20f. (City or town) St. George Creek	(County) St. Mary's	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE A. Sean K.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) Leroy G. Webster		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
		Address (Street, city, town, or county) Great Mills, Maryland, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 5/22/67		23c. NAME OF CEMETERY OR CREMATORIUM St. Paul's Cemetery		23d. LOCATION (City or Town) (County) (State) Wenona Somerset Md.		
24. FUNERAL DIRECTOR Leroy G. Webster		ADDRESS Rt. 3 Princess Anne, Md.		25a. REC'D BY REGISTRAR Princess Anne, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge		
DATE MAY 24 1967								

81570

81570

CHALYBATE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1
07235

CERTIFICATE OF DEATH

07213

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the funeral. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 12 HRS.		b. COUNTY ST. MARY'S	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. GEORGE ISLAND.		
d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MARGARET ESTHER THOMPSON			4. DATE OF DEATH Month Day Year MAY 16 1967		
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH OCT. 7, 1922	9. AGE (In years last birthday) 44 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) NEW HAMPSHIRE			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME HAROLD L HUDSON			14. MOTHER'S MAIDEN NAME ALTA MAE SIMONBS		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 008-10-4434		
17. INFORMANT JAMES VERNON THOMPSON			Address SAME AS #2 ABOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>asphyxia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Carcinoma of lung</i> DUE TO lost. (c)			INTERVAL BETWEEN ONSET AND DEATH <i>24 hr.</i> <i>8 mo.</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from causes and on the date stated above.					
22a. SIGNATURE <i>James Fenwick</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>5-18-67</i>		
22c. PHYSICIAN'S NAME (Type) JOHN F. FENWICK, M.D.		22d. ADDRESS LEONARDTOWN, MARYLAND.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/19/67		23c. NAME OF CEMETERY OR CREMATORIAL ST. FRANCIS XAVIER	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MD.		23d. LOCATION (City or Town) (County) (State) ST. GEORGE ISLAND ST. MARY'S	
				25a. REC'D BY REGISTRAR Charles Judge	
				25b. REGISTRAR'S SIGNATURE MAY 19 1967	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07236

07214

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ST. MARY'S		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ST. MARY'S		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HOLLYWOOD		c. LENGTH OF STAY IN lb 13 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HOLLYWOOD,		d. STREET ADDRESS 18-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First LOUISE	Middle WEEKS	Lost	4. DATE OF DEATH Month MAY	Month 1,	Doy 19 67	
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 8, 1888	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. DAYS 0	Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME FREDERICK LOHMAN		14. MOTHER'S MAIDEN NAME ELIZABETH ??		Address				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDISON EMMETT WEEKS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH immed
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE William D. Boyd M.D. EXAMINER'S NAME (Type)
22. DATE SIGNED 5-4-67								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 6, 1967		23c. NAME OF CEMETERY OR CREMATORIUM EBENEZER CEMETERY		23d. LOCATION (City or Town) (County) (State) GREAT MILLS, MARYLAND		
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		ADDRESS		25a. REC'D BY REGISTRAR MAY 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

5
1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

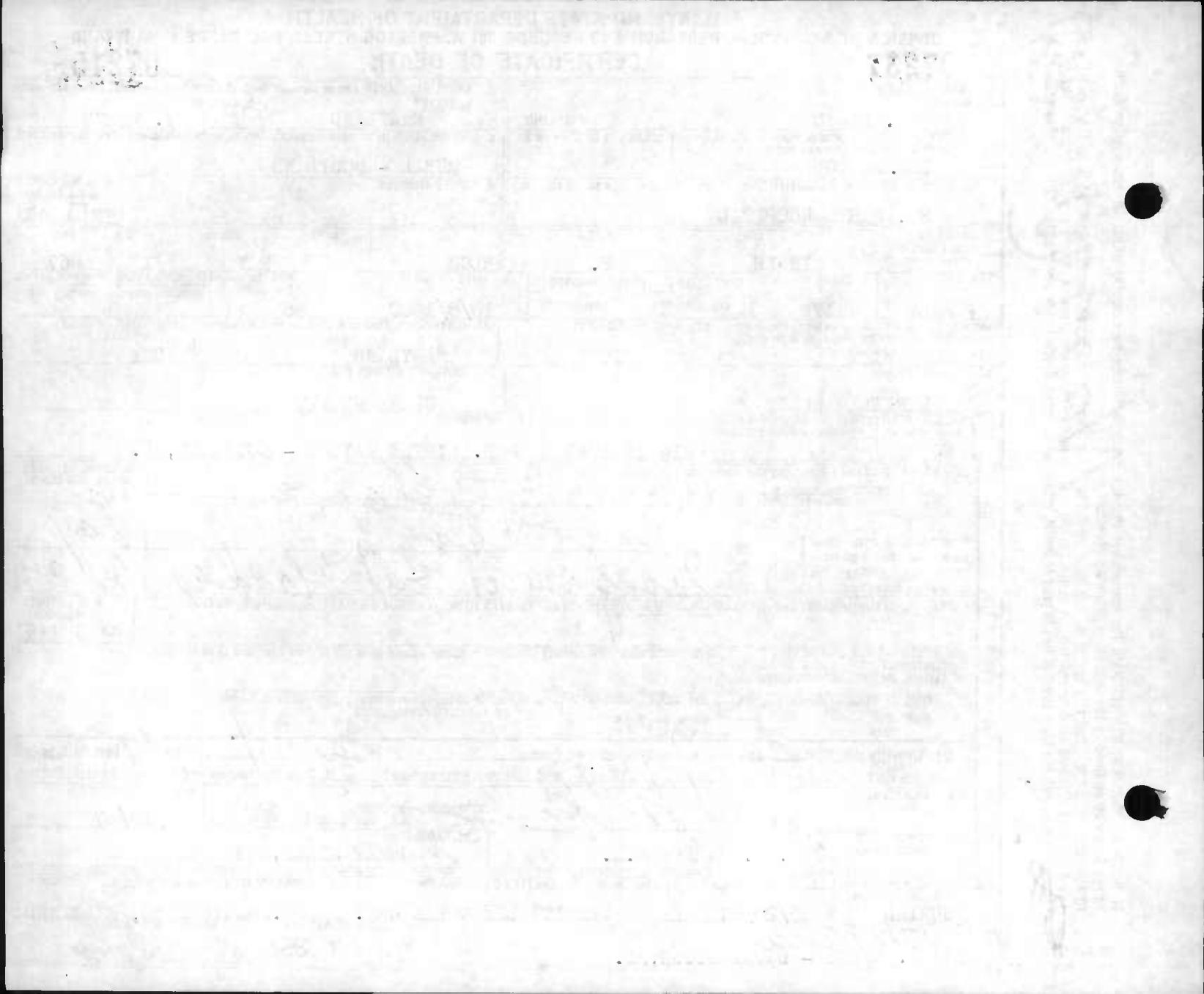
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07237

CERTIFICATE OF DEATH

07215

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND ST. MARYS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - SCOTLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARYS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MINNIE		First H.	Middle WELCH
4. DATE OF DEATH MAY 17 1967	Month	Day	Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. OATE OF BIRTH 10/8/1880
9. AGE (In years last birthday) 86 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DANIEL HAMMETT		14. MOTHER'S MAIDEN NAME CLARA HEWETT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214 36 1742	17. INFORMANT Address MRS. MYRTLE TAYLOR - SCOTLAND, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Collapse Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. Septicemia DUE TO (b) Lungmous Gall-bladder DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
19. WAS AUTOPISY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) GREAT MILLS, MARYLAND
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1967 , to 3/17/67 , that (I) (we) last saw the deceased alive on 1967 , and that death occurred at GREAT MILLS, MARYLAND , from the causes and on the date stated above.			
22a. SIGNATURE <i>JAS. P. JARBOE</i>			
22b. DATE SIGNED 5/19/67			
22c. PHYSICIAN'S NAME (Type) JAS. P. JARBOE M.D.		22d. ADDRESS GREAT MILLS, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/20/67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS TRINITY EPISCOPAL CEM.		23d. LOCATION (City, town or county) (State) ST. MARYS CITY, MARYLAND	
24. FUNERAL DIRECTOR John M. Welch		25a. REC'D BY REGISTRAR DATE MAY 23 1967	
JOHN M. WELCH - LEONARDTOWN, MD.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07238

CERTIFICATE OF DEATH

07216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGE RURAL		c. LENGTH OF STAY IN lb 2 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marbury 082					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RIDGELLS NURSING HOME				d. STREET ADDRESS					
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First ALEXANDER	Middle B.	Last WRIGHT	4. DATE OF DEATH	MAY	Month	Day	Year
5. SEX		6. COLOR OR RACE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
MALE		WHITE			APRIL 26, 1880				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired. Naval Rep. 145. Gout.				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) CHARLES COUNTY, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Wright				14. MOTHER'S MAIDEN NAME Sarah Barker					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Wilson W. Wright, Accokeek, MD		Address RT. 2 BX. 393			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation INTERVAL BETWEEN ONSET AND DEATH min. 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Infarction, by Coronary Artery Disease (c) grt									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec 1966 to 5/26 1967 , that (I) (we) last saw the deceased alive on 5/26 1967 , and that death occurred at 633 M , from causes and on the date stated above.									
22a. SIGNATURE James P. Jarboe		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/26/67					
22c. PHYSICIAN'S NAME (Type) JAMES P. JARBOE M. D.		22d. ADDRESS GREAT MILLS, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-28-'67		23c. NAME OF CEMETERY OR CREMATORIAL Park Hill		23d. LOCATION (City or Town) (County) (State) Marbury Chas. Md.			
24. FUNERAL DIRECTOR The Hunt Funeral Home, Waldorf, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

